WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING INFORMATION

Date ______ / ______ / ______

PATIENT IDENTIFYING INFORMATION

LAST NAME ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR.	FIRST NAME	MIDDLE	DATE OF BIRTH / /	AGE	
HOME ADDRESS	APARTMENT P.O. BOX	CITY	STATE	ZIP	
DRIVERS LICENSE NUMBER	SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	GENDER ☐ MALE ☐ FEMALE	RACE	ETHNICITY
HOME TELEPHONE ( )	OFFICE TELEPHONE ( )	MOBILE TELEPHONE ( )	EMAIL ADDRESS		
EMPLOYER (SCHOOL)	OCCUPATION / (GRADE)	HOBBIES / LIFESTYLE			

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ INSURANCE	☐ LOCATION	☐ REFERRED BY FRIEND	WHOM MAY WE THANK FOR REFERRING YOU?
☐ GOOGLE	☐ WEBSITE	☐ REFERRED BY DOCTOR	

IF PATIENT IS UNDER 18 YEARS OR STUDENT

NAME OF PARENT / GUARDIAN	HOME TELEPHONE	WORK TELEPHONE	MOBILE TELEPHONE

EMERGENCY CONTACT

EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE - PRIMARY	TELEPHONE - MOBILE

MEDICAL INFORMATION

NAME OF **PRIMARY CARE PHYSICIAN**	DATE OF LAST **PHYSICAL** EXAM	NAME (PLACE) OF PREVIOUS **EYE** DR	DATE OF LAST **EYE** EXAM

VISION INSURANCE COVERAGE

NAME OF INSURANCE COMPANY - **VISION COVERAGE**	GROUP NAME	GROUP NUMBER	INSURED IDENTIFICATION CARD #
NAME OF POLICY HOLDER MEMBER	MEMBER DATE OF BIRTH	MEMBER SOCIAL SECURITY NUMBER	INSURANCE COMPANY TELEPHONE NUMBER
RELATIONSHIP TO PATIENT	MEMBER EMPLOYER	MEMBER WORK TELEPHONE	MOBILE TELEPHONE

MEDICAL INSURANCE COMPANY

NAME OF **MEDICAL INSURANCE** COMPANY	POLICY HOLDER NAME (EMPLOYEE)	POLICY HOLDER SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
GROUP NAME	GROUP NUMBER	ID NUMBER	TELEPHONE NUMBER OF INSURANCE COMPANY

ABOUT YOUR EYE EXAMINATION

Several procedures are required to examine the health of your eyes and determine treatment and/or the prescription for your eyewear. The comprehensive examination generally requires the instillation of eye drops to ***dilate the pupil of the eye***. Dilating drops allow the doctor to examine the structures inside of the eye. These drops may result in ***light sensitivity, hazy vision*** and ***difficulty focusing at near***, for a duration of *four (4) to eight (8) hours*. Please exercise caution while driving, operating equipment, or reading during the duration of these effects.

☐ I acknowledge the importance of **dilating drops** and understand the effects on my vision. I wish to **ACCEPT** **DECLINE** the **DILATING EYE DROPS**

☐ I have read and understand the information on the **Optos Digital Retinal Exam (Add $19.00)** I wish to **ACCEPT** **DECLINE** the **Digital Retinal Exam**

Patient or legally authorized individual signature ______ Date ______

Printed name if signed on behalf of the patient ______ Relationship (parent, legal guardian, personal representative) ______

PATIENT MEDICAL HISTORY

REASON FOR VISIT:

- ☐ Annual Examination
- ☐ Eye Health Evaluation
- ☐ Pre-op or Post-op Care
- ☐ Emergency, Injury, Trauma
- ☐ Other: ______
- ☐ Contact Lens Fitting
- ☐ LASIK Consultation
- ☐ Diabetic Eye Exam
- ☐ Glaucoma Evaluation

Date of your last eye exam? ______

DO YOU CURRENTLY?

	YES	
Wear glasses?	☐	How long? ______
Wear contact lenses?	☐	Brand? ______
		Years Worn? ______
Do you work on a computer?	☐	# Hours per day______

ARE YOU IN INTERESTED IN?

	YES	
Contact Lenses?	☐	Type?
Changing your eye color?		
Seeing without glasses?	☐	______
LASIK eye surgery?	☐	______
	☐	______

HAVE YOU HAD?

	YES	Please Describe
Cataract surgery	☐	______
Eye muscle surgery	☐	______
Retinal Surgery	☐	______
Refractive surgery (LASIK)	☐	______
LASIK Consultation	☐	______
Eye injury or Eye Trauma	☐	______
Foreign Body	☐	______
Corneal Scars	☐	

DO YOU EXPERIENCE? YES

- ☐ Blurred vision
- ☐ Burning
- ☐ Distorted vision
- ☐ Double vision
- ☐ Drooping eyelid
- ☐ Dryness
- ☐ Excess tearing
- ☐ Eye pain or soreness
- ☐ Flashes of light
- ☐ Floaters
- ☐ Foreign body sensation
- ☐ Glare / light sensitivity
- ☐ Eye or eyelid infection
- ☐ Itching
- ☐ Loss of side vision
- ☐ Loss of vision
- ☐ Mucous discharge
- ☐ Night driving difficulty
- ☐ Redness
- ☐ Sandy or gritty feeling
- ☐ Tired eyes
- ☐ Uncomfortable glasses
- ☐ Other ______ ______

SOCIAL HISTORY

Do you Smoke?	YES	# ______ packs per day
Do you Drink Alcohol?	YES	# ______drinks per week

FEMALES

Are you Pregnant or Nursing? YES NO

OTHER DISORDERS / DISEASES

Please Describe ______

VISION HISTORY

Do you or any blood relatives have any vision disorders?

M = mother **F** = father **S** = sibling -sister/brother **GP** = grandparent

☐ NO KNOWN EYE/VISION CONDITIONS	YOU: YES	YOU: NO	FAMILY MEMBER
Amblyopia / Lazy eye	☐	☐	M F S GP
Blindness	☐	☐	M F S GP
Cataracts	☐	☐	M F S GP
Color blindness	☐	☐	M F S GP
Crossed / turned eyes	☐	☐	M F S GP
Diabetic Retinopathy	☐	☐	M F S GP
Dry Eyes	☐	☐	M F S GP
Glaucoma	☐	☐	M F S GP
Herpes Simplex Keratitis	☐	☐	M F S GP
Keratoconus	☐	☐	M F S GP
Macular degeneration	☐	☐	M F S GP
Retinal Detachment	☐	☐	M F S GP
Other Vision Disorder(s)			

HEALTH HISTORY

Do you or any blood relatives have health disorders?

☐ NO KNOWN HEALTH CONDITIONS	YOU: YES	YOU: NO	FAMILY MEMBER
Cardiovascular , Heart disease	☐	☐	M F S GP
Cholesterol	☐	☐	M F S GP
High Blood Pressure, Stroke	☐	☐	M F S GP
Diabetes - Type 1 or Type 2	☐	☐	M F S GP
Ears, Nose, Sinusitis, Throat	☐	☐	M F S GP
Cough / Cold / Infection	☐	☐	M F S GP
Hearing Impairment	☐	☐	M F S GP
Endocrine, Hormonal Disorder	☐	☐	M F S GP
Thyroid Disorder	☐	☐	M F S GP
Genital, Kidney, Bladder, Urinary Disease	☐	☐	M F S GP
Menopause, Endométrioses	☐	☐	M F S GP
Sexually Transmitted Disease	☐	☐	M F S GP
Hematologic/ Blood / Lymph Disorders	☐	☐	M F S GP
Anemia, Sickle Cell	☐	☐	M F S GP
Immunologic, HIV Positive (AIDS)	☐	☐	M F S GP
Collagen Vascular, Lupus	☐	☐	M F S GP
Muscles, Bones, Joints, Arthritis	☐	☐	M F S GP
Fibromyalgia	☐	☐	M F S GP
Multiple Sclerosis	☐	☐	M F S GP
Neurological, Headaches Migraines	☐	☐	M F S GP
Dizziness / vertigo	☐	☐	M F S GP
Multiple Sclerosis	☐	☐	M F S GP
Seizures	☐	☐	M F S GP
Psychiatric, Anxiety, Depression	☐	☐	M F S GP
Insomnia	☐	☐	M F S GP
Respiratory, Breathing	☐	☐	M F S GP
Asthma, Bronchitis, Emphysema	☐	☐	M F S GP
Skin, Integumentary, Acne, Rosacea	☐	☐	M F S GP
Basil Cell, Skin Cancer	☐	☐	M F S GP
Eczema, Psoriasis, Dermatitis	☐	☐	M F S GP
Herpes Simplex / Zoster / Shingles	☐	☐	M F S GP
Stomach, Gastrointestinal Disease	☐	☐	M F S GP
Hepatitis	☐	☐	M F S GP
General Constitution	☐	☐	M F S GP
Fatigue, Weakness / Numbness	☐	☐	M F S GP

MEDICATION		ALLERGIES
List all medications and conditions treated (include vitamins, recreational and over the counter drugs)	**Condition being Treated**	List all drug and food allergies (include medications, food, tape, latex and dyes)
☐ NONE	☐ NONE	☐ NONE ☐ ENVIRONMENTAL ☐ SEASONAL

FOR OFFICE USE ONLY

☐ FORM SUBMITTED INCOMPLETE BY PATIENT

TECHNICIAN SIGNATURE	INITIAL REVIEW DATE	DATE REVIEWED & UPDATED	TECHNICIAN SIGNATURE
PHYSICIAN SIGNATURE	INITIAL REVIEW DATE	DATE REVIEWED & UPDATED	TECHNICIAN SIGNATURE